LETTERS

ABORTION AMONG COUPLES IN RURAL BANGLADESH

Gipson and Hindin[1] provide a valuable insight into understanding pregnancy terminations in rural Bangladesh. We recognize the necessity of addressing the context of abortion in order to develop services to tackle the significant morbidity and mortality associated with unsafe practices. The use of quantitative analysis supported by interviews gives a much-needed depth to the understanding of these issues, particularly in regards to the significant impact of male partners' fertility preferences on pregnancy outcomes.

However, some aspects of the methodology prompt further discussion. We question the validity of the approach used to ascertain pregnancy (1 missed period, fertile, and not lactating). It would also have been helpful to have had more information about the participants who were lost to follow-up, and separately about those who missed a period but were not pregnant. We also query the use of walking distance to the nearest health center as a proxy for access to health services and we question whether the difference between walking for 5 minutes and 10 minutes can define access appropriately, especially when recognizing access is such a multidependent issue influenced by many factors, including partners' preference, health care preferences, and economic status. In addition, although the interviews provide added insight, we have reservations regarding the reliability of the apparent use of only 1 researcher to identify key themes from the transcripts.

Gipson and Hindin consider the implications for life in rural Bangladesh but we question the extent to which the results of such research—on a rural area in the southwest of the country—can be representative of other rural areas of Bangladesh. For example, Gipson and Hindin[1] found 11% of pregnancies were terminated compared with 18% nationally. Further research seeking to provide insights into approaches to abortion in other areas of Bangladesh would be useful.

We welcome the authors' comments on these points and concur with their valuable recognition of the impact of male partners on termination-seeking behavior and of its significant public health implications. Targeting men in these populations with education programs regarding family planning would appear to be beneficial in reducing the frequency of pregnancy terminations. Also, continuing to support the training of health care professionals in the delivery of safe, hygienic menstrual regulation services would be beneficial in reducing the use of informal methods in abortion attempts. ■

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The ghost bike for Amelia Geocos was recently dedicated at 1st Avenue and E 49th Street in Manhattan by loving family and friends. Photograph by Philipp Rassmann. Printed with permission.

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Contributors

R. Burnie drafted the letter following discussion of ideas at a journal club with N. Williams and I.J. Robbé. All authors helped to review drafts of the letter.

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Reference

1. Gipson JD, Hindin MJ. "Having another child would be a life or death situation for her": understanding pregnancy termination among couples in rural Bangladesh. *Am J Public Health.* 2008;98(10):1827–1832.

GIPSON AND HINDIN RESPOND

We appreciate the opportunity to respond to the issues raised by Burnie et al. regarding our mixed-method analysis of pregnancy termination in Bangladesh.

With respect to ascertainment of pregnancy status, all women within the Sample Registration System (SRS) households are asked to report on their menstrual status during the quarterly visits. If amenorrheic, women are queried as to the possible cause (e.g., use of injectable contraception, suspected pregnancy). If a woman is unsure of her pregnancy status, her record is flagged in the SRS database for follow-up. If her pregnancy is confirmed, she is asked for the date of her last menstrual period. Albeit imperfect, this method is less subject to recall bias as compared with retrospective reporting of pregnancies and pregnancy loss.[1,2] A more detailed explanation of the SRS and pregnancy ascertainment are described elsewhere.[3,4]

Attrition over the study period was relatively low as compared with other longitudinal data sets. The sample was comprised of couples in which both spouses answered the 1998 fertility questions. Of these couples, over 82% remained active through the 5-year study period. Even when comparing the sample women to all women who participated in the 1998 survey (n=5273), there were no significant differences ($P < .05$) apart from a slightly higher mean number of children among our sample (2.45 vs 2.37 children; P value=0.035).

We agree with Burnie et al. that walking distance does not wholly define access. However, given the existing secondary data available for this analysis and literature linking higher mobility with lower fertility among Bangladeshi women,[5] we felt walking distance to be the most appropriate available proxy measure to assess the potential physical and psychological barriers for women in accessing health services in this context.

During qualitative data collection, there were nightly staff meetings in the field, in addition to further crystallization of study findings by the entire study team through peer review of transcripts and memo-writing on emerging and dominant themes. The themes identified during the fieldwork served as a basis for the results presented.

Lastly, we would like to concur with Burnie et al. that this study is not meant to be representative of all of Bangladesh, or even all of rural Bangladesh. Despite limitations, these data shed light on the contextual circumstances of pregnancy termination. We hope that our study prompts further investigation and a more holistic understanding of pregnancy termination within and outside of Bangladesh. ■

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Contributors

J.D. Gipson researched the literature and drafted the letter. M.J. Hindin contributed to the discussion and final edited version of the letter.

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Human Participant Protection

The institutional review boards of the Johns Hopkins Bloomberg School of Public Health and the International Centre for Health and Population Research approved this study. Participants provided verbal informed consent.

References

1. Udry JR, Gaughan M, Schwingl PJ, van den Berg BJ. A medical record linkage analysis of abortion underreporting. *Fam Plann Perspect.* 1996;28(5):228–231.
2. Casterline JB. Collecting data on pregnancy loss: a review of evidence from the World Fertility Survey. *Stud Fam Plann.* 1989;20:81–95.
3. Gipson JD. *A Mixed-Method Study of Unintended Pregnancy in Bangladesh. Department of Population and Family Health Sciences* [dissertation]. Baltimore, MD, Johns Hopkins Bloomberg School of Public Health; 2006.
4. Mozumder KA, Koenig MA, Phillips JF, Murad S. The Sample Registration System: An innovative system for monitoring demographic dynamics. *Asia Pac Popul J.* 1990;5(3):63–72.
5. Balk D. Individual and community aspects of women's status and fertility in rural Bangladesh. *Popul Stud.* 1994;48:21–45.

MEASURING THE VALUE OF PUBLIC HEALTH SYSTEMS

I applaud Neumann et al.'s examination of the disconnect between health economists and public health practioners.[1] Their findings are similar to the decade-old observations of Weinstein and Melchreit in the field of HIV prevention.[2]

The Centers for Disease Control and Prevention launched HIV prevention community planning in 1993 as a participatory process by which health departments were to garner broad, structured, evidence-based input when setting priorities.[2] By 1994, the cost and effectiveness of HIV prevention programs were clearly identified as factors that should be considered in the community planning process and early technical assistance documents on economic evaluation became available.[2] In 1998, Weinstein and Melchreit reflected on the nascent experiences of using economic evaluation in community planning and other HIV prevention policy making.[2] They asserted that key barriers to further utilization of economic evaluation methods and data included: (1) lack of useful studies, (2) lack of in-house expertise, (3) conflicts of interest, (4) lack of generalizability of studies across jurisdictions, (5) studies focusing on individual interventions rather than on program portfolios, (6) legal prohibitions of cost-effective yet controversial interventions, and (7) unintended consequences of using economic evaluations.[2] Weinstein and Melchreit also surveyed 57 health